VACCINE ADVERSE EVENT REPORTING SYSTEM 24 Hour Toll-free information line 1-800-822-7967 P.O. Box 1100, Rockville, MD 20849-1100 PATIENT IDENTITY KEPT CONFIDENTIAL			For CDC/FDA Use Only VAERS Number Date Received		
Patient Name:	Vaccine administered	d by (Name):	Form completed by (Name):		
Last First M.I. Address	Responsible Physician Facility Name/Addres	s	Relation Vaccine Provider Patient/Parent to Patient Manufacturer Other Address (if different from patient or provider)		
City State Zip Telephone no. ()	City Telephone no. (State Zip	5. Sex	State Zip	
7. Describe adverse event(s) (symptoms, signs, time course) and treatment, if any			M F 8 Check all appropriate: Patient died (date //y) Life threatening illness mm dd yy Required emergency room/doctor visit Required hospitalization (days) Resulted in prolongation of hospitalization Resulted in permanent disability None of the above		
9. Patient recovered YES NO UNKNOWN			10. Date of vaccin	ation 11 Adverse event onset	
12. Relevant diagnostic tests/laboratory data			mm dd ,	mm dd yy AM PM TimePM	
Vaccine (type) Ma. a. b. c. d.	nufacturer	Lot number	Route/Sit	No. Previous doses	
14. Any other vaccinations within 4 weeks of date listed in no. 10 Vaccine (type) Manufacturer Lot number Route/Site a.		No. Previou doses	s Date given		
b					
Public health clinic/hospital Other/u 18. Illness at time of vaccination (specify)				medical conditions (specify)	
202.0) 02	10 1100111 00 00 1111			for children 5 and under	
this adverse event previously?		oz. 23. No. of brothers and sisters			
21. Adverse event following prior vaccination (Adverse Onset Typ Event Age Vac	check all applicable, specify) e Dose no. cine in series	Only for reports subm 24. Mfr. / imm. proj. rep		turer/Immunization project received by mfr. / imm. proj.	
In patient		26. 15 day report?	6. 15 day report? 27. Report type		
☐ In brother		□Yes □No □ Initial □ Follow-Up			
Health care providers and manufacturers Reports for reactions to other	are required by law (42 USC 3 r vaccines are voluntary except	300aa-25) to report reactions to at when required as a condition	vaccines listed in the V of immunization grant a	accine Injury Table. wards.	

"Fold in thirds, tape & mail - DO NOT STAPLE FORM"

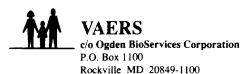


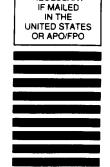
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BUSINESS REPLY MAIL

FIRST CLASS MAIL PERMIT NO. 1895 ROCKVILLE, MD

POSTAGE WILL BE PAID BY ADDRESSEE





NO POSTAGE NECESSARY

DIRECTIONS FOR COMPLETING FORM

(Additional pages may be attached if more space is needed.)

GENERAL

- Use a separate form for each patient. Complete the form to the best of your abilities. Items 3, 4, 7, 8, 10, 11, and 13 are considered
 essential and should be completed whenever possible. Parents/Guardians may need to consult the facility where the vaccine was
 administered for some of the information (such as manufacturer, lot number or laboratory data.)
- Refer to the Vaccine Injury Table (VIT) for events mandated for reporting by law. Reporting for other serious events felt to be related but not on the VIT is encouraged.
- Health care providers other than the vaccine administrator (VA) treating a patient for a suspected adverse event should notify the VA and provide the information about the adverse event to allow the VA to complete the form to meet the VA's legal responsibility.
- These data will be used to increase understanding of adverse events following vaccination and will become part of CDC Privacy
 Act System 09-20-0136, "Epidemiologic Studies and Surveillance of Disease Problems". Information identifying the person who
 received the vaccine or that person's legal representative will not be made available to the public, but may be available to the vaccinee
 or legal representative.
- · Postage will be paid by addressee. Forms may be photocopied (must be front & back on same sheet).

SPECIFIC INSTRUCTIONS

Form Completed By: To be used by parents/guardians, vaccine manufacturers/distributors, vaccine administrators, and/or the person completing the form on behalf of the patient or the health professional who administered the vaccine.

- Item 7: Describe the suspected adverse event. Such things as temperature, local and general signs and symptoms, time course, duration of symptoms diagnosis, treatment and recovery should be noted.
- Item 9: Check "YES" if the patient's health condition is the same as it was prior to the vaccine, "NO" if the patient has not returned to the pre-vaccination state of health, or "UNKNOWN" if the patient's condition is not known.
- Item 10: Give dates and times as specifically as you can remember. If you do not know the exact time, please
- and 11: indicate "AM" or "PM" when possible if this information is known. If more than one adverse event, give the onset date and time for the most serious event.
- Item 12: Include "negative" or "normal" results of any relevant tests performed as well as abnormal findings.
- Item 13: List ONLY those vaccines given on the day listed in Item 10.
- Item 14: List ANY OTHER vaccines the patient received within four weeks of the date listed in Item 10.
- Item 16: This section refers to how the person who gave the vaccine purchased it, not to the patient's insurance.
- Item 17: List any prescription or non-prescription medications the patient was taking when the vaccine(s) was given.
- Item 18: List any short term illnesses the patient had on the date the vaccine(s) was given (i.e., cold, flu, ear infection).
- Item 19: List any pre-existing physician-diagnosed allergies, birth defects, medical conditions (including developmental and/or neurologic disorders) the patient has.
- Item 21: List any suspected adverse events the patient, or the patient's brothers or sisters, may have had to previous vaccinations.

 If more than one brother or sister, or if the patient has reacted to more than one prior vaccine, use additional pages to explain completely. For the onset age of a patient, provide the age in months if less than two years old.
- Item 26: This space is for manufacturers' use only.